STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING: _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of 2 State hospital complaints. Complaint Number: IN 00131818 Unsubstantiated: lack of sufficient evidence. Complaint Number: IN00132278 Unsubstantiated: lack of sufficient evidence. Date: 11-18-13, 11-19-13 and 11-20-13 Facility Number: 005051 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Indiana University Health is in compliance with 410 IAC 15-1.5-2, Infection control, 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-1.5-7, Pharmaceutical services, Indiana Hospital Licensure Rules. QA: claughlin 12/05/13	S 000		